Travis Dockter MS, CCC – SLP

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Authorization for Release of Information

Child's Name: ____

Child's Date of Birth: ____________________

The above-named child is or has been a patient of:

Name of Person, Provider, or Facility: ____________________________________

Address: ____

Phone Number: _______________________ Fax Number: _______________________

The parent or guardian of the above-named child hereby authorizes Travis Dockter to:

- ❑ Request educational / health information from the above-named person, provider, or facility.
- ❑ Send educational / health information to the above-named person, provider, or facility.
- ❑ Discuss educational / health information with the above-named person, provider, or facility.

The parent or guardian of the above-named child hereby indicates that this authorization is to expire:

- ❑ Upon one-time receipt, sharing, or discussing of the information.
- ❑ In six months from the signed date at the bottom of this form.
- ❑ In one year from the signed date at the bottom of this form.
- ❑ In three years from the signed date at the bottom of this form.
- ❑ On this date: ____________________.

The parent or guardian of the above-named child sets the scope of the information received, sent, and/or discussed as follows:

- ❑ All information regarding assessment, diagnosis, and treatment of the child's condition(s), concern(s), or disease(s).
- ❑ All information regarding care received by the child between the dates of:

  ____________________ and ____________________.
  Starting Date Ending Date

- [ ] Other information (please specify): ____

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Additional Information:

- This authorization is effective for the above-requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date indicated. Additionally, you may revoke this authorization at any time by submitting a written request to Travis Dockter. Your revocation will be honored except to the extent that it has been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be released.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional releases or disclosures may not be prohibited by law. Travis Dockter is not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist Travis Dockter or other above-named provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility of benefits.

PLEASE NOTE: Unless otherwise specified by law, Travis Dockter will release only that information which has been created such as chart notes, summaries, and consultation reports. Records created by other providers must be obtained directly from those other providers. Some providers charge fees associated with copying your records. You will need to contact those individual offices to confirm.

Authorization:

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Printed Name of Parent or Guardian

____ ____________________
Signature of Parent or Guardian Date of Signature